Office - Supreme Court, U.S.
FILED
JUL 11 1983
ALEXANDER L. STEVAS
CLERK

83-29

NO.

IN THE

Supreme Court of the United States

October Term, 1982

IREDELL MEMORIAL HOSPITAL, INC.,

Petitioner,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR A WRIT OF CERTIORARI

TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

ANTHONY H. BRETT
Counsel of Record, with
RODDEY M. LIGON, JR.
Womble Carlyle Sandridge & Rice
Post Office Drawer 84
Winston-Salem, N.C. 27102
Telephone: (919) 721-3620
Counsel for Petitioner

APPELLATE PRINTING SERVICES, INC., HERITAGE BLDG., RICHMOND, VA (804) 643-7789

QUESTIONS PRESENTED

1. Whether the reasonable costs to a hospital of providing free medical care to indigents as required by the Hill-Burton program is proportionately reimbursable by the Medicare program?
2. Whether a compensable taking has occurred by the enactment of federal legislation which repudiates pre-existing rights of a hospital to Medicare reimbursement for Hill-Burton care?
3. Whether a violation of due process has occurred by the enactment of federal legislation which repudiates pre-existing rights of a hospital to Medicare reimbursement for Hill-Burton care?
4. Whether a compensable taking, a violation of due process or a violation of separation of powers has occurred by the enactment of federal legislation which extinguishes a pre-existing judgment against the United States?

PARTIES TO THE PROCEEDING

The parties to this proceeding are Iredell Memorial Hospital, Inc., a non-profit corporation without subsidiaries, and the United States through the Department of Health and Human Services.[1]

---

[1]The American Hospital Association, South Carolina Hospital Association, North Carolina Hospital Association, Virginia Hospital Association, and West Virginia Hospital Association appeared before the Court of Appeals as Amici Curiae on behalf of Petitioner.

TABLE OF CONTENTS

QUESTIONS PRESENTED i

PARTIES TO THE PROCEEDING ii

TABLE OF AUTHORITIES v

OPINIONS BELOW viii

GROUNDS FOR JURISDICTION viii

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED . . ix

STATEMENT OF THE CASE 1

REASONS FOR ALLOWANCE OF THE WRIT:

1. The Judgment Is In Conflict With The Decision Of Another Federal Court Of Appeals . . . 6

2. The Action Involves Important Questions Of Federal Law Which Should Be Settled By This Court 8

3. The Judgment Is In Conflict, In Principle, With Decisions Of This Court 16

CONCLUSION 19

APPENDIX:

Opinion Of The Court Of Appeals . . A.1

Opinion Of The District Court . . . A.12

Opinion Of The Provider Reimbursement Review Board . . . A.30

Order Extending Time To File Petition For Writ Of Certiorari . A.41

Final Agency Action A.42

U.S. Const. Art. III, § 1 . . . . A.43

U.S. Const. Amend. V A.44

5 U.S.C. § 706(2)(A) A.45

5 U.S.C. § 291c(e) A.46

42 U.S.C. § 1395f(b)(1) A.48

42 U.S.C. § 1395x(v)(1)(A) A.49

42 U.S.C. § 1395oo(f) A.53

Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, Section 106 (96 Stat. 337) . . . A.57

42 C.F.R. § 405.311 . . . . . A.59

42 C.F.R. § 405.312 . . . . . A.61

42 C.F.R. § 405.402 . . . . . A.64

42 C.F.R. § 405.403(b) A.73

42 C.F.R. § 405.420 . . . . . A.74

42 C.F.R. § 405.451 . . . . . A.79

47 Fed. Reg. 43654, 43658 (October 1, 1982) A.84

TABLE OF AUTHORITIES

Cases:

Catholic Medical Center v. New Hampshire-Vermont Hospitalization Service, Inc., No. 82-1808 (1st Cir. May 4, 1983) 11

Chicago & S. Air Lines, Inc. v. Waterman S. S. Corp., 333 U.S. 103 (1948) 18

Harper-Grace Hospitals v. Schweiker, 691 F.2d 808 (6th Cir. 1982) 11, 16

Hodges v. Snyder, 261 U.S. 600 (1923) 18, 19

Iredell Memorial Hospital, Inc. v. Schweiker, 699 F.2d 196 (4th Cir. 1983) . . . . . passim

Johnson County Memorial Hospital v. Schweiker, No. 82-1805 (Oct. Term, 1982) 11

Louisville Joint Stock Land Bank v. Radford, 295 U.S. 555 (1935) 17

Lynch v. United States, 292 U.S. 571 (1934) 17

Memorial Hospital v. Heckler, No. 81-6230 (11th Cir. June 6, 1983) 11

Metropolitan Medical Center v. Harris, 693 F.2d 775 (8th Cir. 1982) 7, 11

Presbyterian Hospital of Dallas v. Harris, 638 F.2d 1381, rehearing en banc denied, 647 F.2d 1121 (5th Cir.) cert. denied, 454 U.S. 940 (1981) 7, 11, 15,16

Saint Mary of Nazareth Hospital v. Department of Health and Human Services, 698 F.2d 1337 (7th Cir. 1983) 11

St. James Hospital v. Heckler, No. 82-____ (Oct. Term, 1982) 11

Thorpe v. Housing Authority, 393 U.S. 268 (1969) 17

United States v. Klein, 80 U.S. (13 Wall.) 128 (1872) 18

United States v. Larionoff, 431 U.S. 864 (1977) 17

Constitution and Statutes:

U.S. Const. art. III, § 1 18

U.S. Const. amend. V 17

5 U.S.C. § 706(2)(A) 1

42 U.S.C. § 291 et. seq. 2

42 U.S.C. § 291c(e) 12

42 U.S.C. § 1395f(b)(1) 13

42 U.S.C. § 1395x(v)(1)(A) 13

42 U.S.C. § 1395oo(f) 1

Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, section 106 (96 Stat. 337) 5, 16, 19

Regulations

42 C.F.R. Part 124, Subparts F and G 10

42 C.F.R. § 405.311 . . . . . 13, 14

42 C.F.R. § 405.312 14

42 C.F.R. § 405.402 . . . . . 13, 14

42 C.F.R. § 405.403(b) 14

42 C.F.R. § 405.420 . . . . . 4, 14

42 C.F.R. § 405.451 14

47 Fed. Reg. 43654, 43658 (October 1, 1982) 5

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit (A. 1)[2] is officially reported as Iredell Memorial Hospital, Inc. v. Schweiker, 699 F.2d 196 (4th Cir. 1983).

The opinion of the United States District Court for the Western District of North Carolina (A. 12) is officially reported as Iredell Memorial Hospital, Inc. v. Schweiker, 535 F.Supp. 795 (W.D.N.C. 1982). The opinion the Provider Reimbursement Review Board (A. 30) is unofficially reported as Iredell Memorial Hospital v. Blue Cross Association, No. 81-D26, Medicare and Medicaid Guide (CCH) 1981-1 Transfer Binder ¶ 30,930 (1981).

GROUNDS FOR JURISDICTION

The judgment of the Court of Appeals

---

[2] "A. ___" references are to the Appendix pages immediately following this Petition.

was entered on February 10, 1983. By an order of the Chief Justice of April 27, 1983 (A. 41), an extension of time within which to petition for certiorari was granted to and including July 10, 1983. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED[3]

Constitution: U.S. Const. art. III, § 1, and U.S. Const. amend. V.

Statutes: 5 U.S.C. § 706(2)(A), 42 U.S.C. § 291c(e), 42 U.S.C. § 1395f(b)(1)[4], 42 U.S.C. § 1395x(v)(1)(A)[5], 42 U.S.C. § 1395oo(f), and Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248, section 106 (96 Stat. 337).

Regulations: 42 C.F.R. § 405.311, 42 C.F.R.

---

[3]The text of these authorities is reproduced in the Appendix beginning at A.1 .

[4] and [5]As in effect at the times at issue in this action.

§ 405.312, 42 C.F.R. § 405.402, 42 C.F.R. § 405.403(b), 42 C.F.R. § 405.420, 42 C.F.R. § 405.451 and 47 Fed. Reg. 43654, 43658 (October 1, 1982).

STATEMENT OF THE CASE

The basis for jurisdiction in the federal court of first instance, the United States District Court for the Middle District of North Carolina, was 42 U.S.C. § 1395oo(f)(A. 53). This matter came before the district court seeking judicial review of a final agency determination of the Respondent[6] which is alleged by the Petitioner[7] to be "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law" in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2)(A). The sole contested issue raised in this action is whether the Hospital is entitled to receive Medicare reimbursement for free medical care provided to indigent patients pursuant

---

[6]Hereinafter referred to as the "Secretary."

[7]Hereinafter referred to as the "Hospital."

to the Hill-Burton program.[8]

The Hospital is a 182-bed general short-term care hospital located in Statesville, North Carolina. The land and hospital building are owned by a municipal corporation, Iredell County, and the facility is operated by the Hospital, a non-profit corporation. The Hospital is a qualified provider of medical services under the Medicare program and, pursuant to its terms, is entitled to reimbursement for its reasonable costs incurred in the provision of necessary medical services to Medicare beneficiaries.

The Hospital received $1,286,568 for an expansion of its facilities pursuant to the Hill-Burton program. Pursuant to the terms of the Hill-Burton Act, 42 U.S.C. §§ 291 et seq., the Hospital is legally

---

[8]All allegations of fact raised by the Complaint were admitted by the Secretary in the Answer.

obligated to provide reasonable amounts of free medical care to indigent patients seeking such care at its facilities. For its fiscal years ending on September 30 of 1977 and 1978, the Hospital provided such free care to indigents in the total amount of $283,943. Pursuant to the principles governing Medicare reimbursement to providers of services, the portion of this total amount of Hill-Burton Act free care which would be attributable to the Medicare program is $120,301.

The Hospital's claim for reimbursement was originally disallowed by Blue Cross Blue Shield of North Carolina in its role as fiscal intermediary pursuant to the Medicare program. Upon administrative review of the disallowance, the Hospital's claim for reimbursement was rejected by the agency through the Provider Reimbursement Review Board (A. 30). The decision of the Provider Reimbursement Review Board

was adopted by the Secretary as final agency action (A. 42). The basis for the Secretary's decision arose from the "charity" exclusion from reimbursement provided by 42 C.F.R. § 405.420 (A. 74).

Upon judicial review of this matter, the district court reversed the Secretary's determination (A. 12). In its decision, the district court held that the Medicare statutes and regulations require reimbursement for necessary and proper costs of services, including indirect costs of providing medical services, such that the costs arising from the provision of free medical care to Hill-Burton indigent patients is a cost which is proportionately reimbursable by the Medicare program as a matter of law. The Secretary filed a timely appeal to the United States Court of Appeals for the Fourth Circuit.

Subsequent to the decision of the district court, but prior to the judgment of

the Court of Appeals at issue, the enactment of the Tax Equity and Fiscal Responsibility Act of 1982, section 106 (A. 57), was raised by the Secretary as grounds for reversal of the district court decision. Section 106 amended the governing Medicare statutes such that the Hospital's costs at issue were defined to be nonreimbursable "charity." In addition, the statute declared that the exclusion from reimbursement shall be effective as to any costs incurred with the exception of "costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals." The Secretary amended the governing regulations to provide for such disallowance of costs by 47 Fed. Reg. 43654, 43658 (October 1, 1982) (A. 84).

The judgment of the Court of Appeals, reversing the district court, held that the costs of providing Hill-Burton free care to

indigents did constitute "charity" within the meaning of the Secretary's regulations. Therefore, the Hospital's claim for Medicare reimbursement was denied.

REASONS FOR ALLOWANCE OF THE WRIT

1. The Judgment Is In Conflict With The Decision Of Another Federal Court Of Appeals.

In its decision, the Court of Appeals noted that a split of circuit authority was in existence with reference to the question of whether the costs of providing Hill-Burton free care to indigents is proportionately reimbursable by the Medicare program.

> Two cases have reached the circuit courts and have resulted in conflicting opinions. The Fifth Circuit has held that these costs were properly reimbursable under the Medicare program, but the Eighth Circuit reached the opposite conclusion, holding that the cost of Hill-Burton required care to indigents was not reimbursable.

> There is much to be said for the analysis contained in each opinion, but we agree with the reasoning of Judge Heaney in the Eighth Circuit opinion, that the Secretary's regulations and construction of both statutes require the conclusion that the costs are not reimbursable.

(A.9-10)(footnote omitted). The two decisions to which the Court of Appeals made reference are Presbyterian Hospital of Dallas v. Harris, 638 F.2d 1381, rehearing en banc denied, 647 F.2d 1121 (5th Cir.), cert. denied, 454 U.S. 940 (1981) (held to be reimbursable) and Metropolitan Medical Center v. Harris, 693 F.2d 775 (8th Cir. 1982)(held to not be reimbursable).

The Court of Appeals, rather than engaging in its own analysis of the proper construction of both statutes, the Medicare Act and the Hill-Burton Act, instead selected to adopt one of the conflicting lines of judicial authority as the rule to govern within its circuit. Without

suggesting that such an approach to appellate review is inappropriate for any given circuit, the Hospital strongly urges this Court to consider the need for national uniformity in the administration of one of the Nation's largest social programs. Whether or not the costs at issue in this action are reimbursable by the Medicare program should not be a question of geography. Instead, the question involved is one of law which should be determined consistently for all affected hospitals throughout the Nation.

2. The Action Involves Important Questions Of Federal Law Which Should Be Settled By This Court.

In addition to the existence of conflicting circuit authority on the question at issue, this Court should allow the writ in order to determine with finality important questions of

federal law. The importance of these questions arises from two related factors. First, the statutes and regulations relating to the administration of the Medicare program are of great importance to the many hospitals throughout the Nation providing care to Medicare benficiaries. Second, the matter at issue in this action has generated considerable litigation in the federal courts and may continue to do so unless it is finally resolved by this Court.

Using the Hospital as just an example, the $120,301 at issue in this action relates to only two years of medical services. Considering the sum involved, once magnified by the total number of years which could be at

issue[9], it becomes apparent that a much larger financial concern is involved. Furthermore, this larger financial concern is one which affects many hospitals, rather than just a few.[10]

Therefore, this matter is worthy of this Court's attention as the ultimate outcome will have a significant impact upon financial resources of a major segment of the health care industry. The importance of this issue is further demonstrated by the

---

[9]The normal length of a hospital's Hill-Burton free care obligation is twenty years. However, this period is subject to extension. See generally, 42 C.F.R. Part 124, Subparts F and G.

[10]Which was the reason for the active involvement of amici curiae hospital associations listed supra at (ii), n. 1.

large volume of litigation which it has spawned[11], a fact noted by the Court of Appeals (A. 9). This volume of litigation was recognized by the Court of Appeals to be an outgrowth of the lack of clarity provided by the governing legislation (A. 9).

---

[11] In addition to this action, Presbyterian Hospital, supra, and Metropolitan Medical Center, supra, four other federal circuits have addressed this question. E.g., Catholic Medical Center v. New Hampshire-Vermont Hospitalization Service, Inc., No. 82-1808 (1st Cir. May 4, 1983); Harper-Grace Hospitals v. Schweiker, 691 F.2d 808 (6th Cir. 1982); Saint Mary of Nazareth Hospital v. Department of Health and Human Services, 698 F.2d 1337 (7th Cir. 1983); Memorial Hospital v. Heckler, No. 81-6230 (11th Cir. June 6, 1983). Furthermore, petitions for writs of certiorari to the United States Court of Appeals for the Seventh Circuit have been filed in Johnson County Memorial Hospital v. Schweiker, No. 82-1805 (Oct. Term, 1982) and St. James Hospital v. Heckler, No. 82-_____ (Oct. Term, 1982). Finally, a large volume of litigation is currently pending in district courts throughout the Nation.

However, it is apparent that the decision of the Court of Appeals with reference to the underlying issue was an incorrect one. As the Court of Appeals noted in its decision that the costs of providing free care to indigents arose from the Hospital's obligations assumed as a consequence of its receipt of Hill-Burton funds, the Court of Appeals should have taken the next step to analyze whether such costs should be treated differently from any other indirect costs of providing medical care.

In this regard, the obligation to provide free care to indigents is, in effect, an indirect cost arising from acceptance of construction funds under the Hill-Burton program. See, 42 U.S.C. § 291c(e). The Medicare program (during the relevant time period) is required by statute to compensate hospitals for

the lesser of either their "reasonable costs" or their "customary charges" with respect to the provision of health care services. 42 U.S.C. § 1395f(b)(1).[12] The costs of providing medical care, including indirect costs, are reimbursable items under the Medicare program. 42 U.S.C. § 1395x(v)(1)(A).

Thus, by failing to take the second step, the Court of Appeals failed to recognize that its decision (and that of the Secretary) was clearly not in accord with federal law. This fact is apparent from a review of the relevant regulations. For example, 42 C.F.R. § 405.402, which provides general principles

---

[12]With respect to the Hospital;s two fiscal years at issue, Medicare reimbursement was determined on a cost basis.

governing reimbursement, states that:

> All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients.

Thus, capital construction costs, such as the ones at issue in this action, clearly qualify for Medicare reimbursement. See generally, 42 C.F.R. §§ 405.402, 405.403(b) and 405.451. The Secretary's position to the contrary as adopted by the Court of Appeals is simply unsupported by the Medicare regulations. See, 42 C.F.R. §§ 405.311, 405.312 and 405.420. In reference to the Secretary's primary argument, that costs relating to the provision of free care to indigents under the Hill-Burton program constitutes "charity", the Court of Appeals held that "While the provision of free services mandated by the Hill-Burton Act may not

conform to the dictionary definition of, nor even to the general concept of, 'charity', the care of indigents required by the Hill-Burton Act is clearly encompassed by the definition given in the Secretary's regulation." (A. 10). However, in light of the undisputed fact that the Hospital has a legal obligation to provide such care, the provision of such care cannot reasonably be deemed to be voluntary or charitable within the meaning of 42 C.F.R. § 405.420.

> It is undisputed that the Hospital was legally obligated to make such expenses, and it is also undisputed that the expenses indirectly benefited Medicare patients by qualifying the Hospital for interest subsidies on construction and modernization projects. The fact that such expenses also benefited indigent persons who were not Medicare beneficiaries is irrelevant to the determinative issue; whether the expenses were a reasonable cost incurred in the provision of services to Medicare patients. We conclude, therefore, that the free care expenses incurred by the Hospital in connection with its obligations under the Hill-Burton

> Act were reasonable costs of providing care to all of its patients, and are consequently reimbursable to the extent that this indirect cost benefited Medicare patients.

Presbyterian Hospital, supra, 638 F.2d at 1387 (footnote omitted). The Court of Appeals' judgment to the contrary makes a mockery of the statutory obligation that hospitals be reimbursed for the full costs of treating Medicare patients.

3. The Judgment Is In Conflict, In Principle, With Decisions Of This Court.

It is probable that the Court of Appeals was greatly influenced by the enactment of Section 106 which proported to disallow the costs at issue in this action.[13] Reliance placed upon the intervening legislation is clearly improper with respect to

---

[13]It is apparent that other federal courts have been so persuaded by Section 106 which has been held to disallow Hill-Burton compliance costs. E.g., Harper-Grace Hospitals, supra n.11.

preexisting obligations of the United States which had been reduced to judgment in this action.

First, it is a clear violation of the principles of due process provided in the Fifth Amendment for the United States to retroactively alter its contractual obligations to others. Lynch v. United States, 292 U.S. 571 (1934); see, United States v. Larionoff, 431 U.S. 864, 879 (1977) and Thorpe v. Housing Authority, 393 U.S. 268, 278-79 (1969).

Second, even if the United States could retroactively alter its contractual obligations to others, such an alteration would constitute a taking within the meaning of the Fifth Amendment such that the Hospital would be entitled to "just compensation" (which in this case would be the amount at issue). Louisville Joint Stock Land Bank v. Radford,

295 U.S. 555 (1935); Hodges v. Snyder, 261 U.S. 600, 603-04 (1923).

Third, due to the fact that the Hospital's rights were reduced to judgment, the United States cannot alter its obligations by subsequent legislation without running roughshod over the separation of powers doctrine. U.S. Const. Art. III, § 1. That a judicial decision determining the rights of the United States with respect to its obligations to private parties may not be abrogated by the legislative branch has been an established principle since the decision in United States v. Klein, 80 U.S. (13 Wall) 128 (1872). The importance of maintaining the separation of powers among the three branches of the federal government in this regard has been continuously recognized since the decision in Klein. E.g., Chicago &

S. Air Lines, Inc. v. Waterman S.S. Corp., 333 U.S. 103, 113 (1948); Hodges, supra, 261 U.S. at 603.

Therefore, it is beyond doubt that the judgment at issue in this action is in conflict, at least in principle, with governing authority of this Court. Insofar as Section 106 is advanced by the Secretary as grounds for disallowance of the Hospital's claimed reimbursement, grave constitutional questions are at issue. The resolution of those questions will have far reaching effects that extend to the very heart of the exercise of legislative power.

CONCLUSION

For the foregoing reasons, the writ of certiorari requested herein should be allowed.

Respectfully submitted,

ANTHONY H. BRETT
Counsel of Record, with
RODDEY M. LIGON, JR.
Womble Carlyle Sandridge & Rice
P. O. Drawer 84
Winston-Salem, N. C. 27102

Counsel for Petitioner

A P P E N D I X

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 82-1208

Iredell Memorial Hospital, Inc.,

Appellee,

v.

Richard S. Schweiker, Secretary of the United States Department of Health and Human Services,

Appellant.

American Hospital Association, and State Hospital Associations for the states of South Carolina, North Carolina, Virginia, West Virginia,

Amicus Curiae.

Appeal from the United States District Court for the Western District of North Carolina, at Statesville. Robert D. Potter, District Judge.

Argued: December 6, 1982

Decided: February 10, 1983

Before: RUSSELL, WIDENER AND SPROUSE, Circuit Judges.

Marleigh D. Dover, Dept. of Justice (J. Paul McGrath, Assistant Attorney General; Charles W. Brewer, Assistant Attorney General; Anthony J. Steinmeyer, Dept. of Justice on brief) for Appellant; Leonard C. Homer (Ober, Grimes & Shriver on brief) for South Carolina Hospital Association, North Carolina Hospital Association, Virginia Hospital Association and West Virginia Hospital Association; (Patricia S. Hofstra on brief) for American Hospital Association; Anthony H. Brett (Roddey M. Ligon, Jr., Womble, Carlyle, Sandridge & Rice on brief) for Iredell Memorial Hospital, Inc.

SPROUSE, Judge:

This action was commenced administratively by Iredell Memorial Hospital, Inc. ("the Hospital"), to obtain reimbursement under the Medicare Act[1] for costs the Hospital incurred in providing free medical care to indigent patients, as required by the Hill-Burton Act.[2] The Blue Cross Association/Blue Cross and Blue Shield of North Carolina, as fiscal Intermediary disbursing Medicare funds, disallowed the Hospital's claims. The Hospital appealed to the federal Provider Reimbursement Review Board ("PRRB"), which upheld the Intermediary. The Secretary of the United States Department of Health and Human Services ("the Secretary") declined to review the PRRB decision, thereby upholding it. The Hospital

---

[1] 42 U.S.C. § 1395 et seq.

[2] 42 U.S.C. § 291 et seq.

then appealed the PRRB decision to the district court, which reversed the Secretary and the PRRB. The district court held that free medical care to indigents required by the Hill-Burton Act is reimbursable as a proper Medicare indirect cost. We reverse, agreeing with the PRRB and the Secretary that such reimbursement is specifically prohibited by regulations promulgated by the Secretary; and that the reimbursement of such costs would be contrary to the purpose of both the Hill-Burton and Medicare Acts.

The Hospital is a 182-bed general short-term hospital located in Statesville, North Carolina, owned by the municipality but operated by a nonprofit organization. In the late 1960's, the hospital received a $1,286,568 grant under the Hill-Burton Act to construct a new wing, expanding the Hospital's capacity from 100 to 182 beds.

The portion of the Hill-Burton Act generating the instant controversy is contained in 42 U.S.C. § 291c(e)(2), which provides:

> [T]here will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

The Secretary has promulgated regulatory guidelines[3] establishing the amount of free care which must be furnished to comply with the Hill-Burton requirement of free care to indigents. The Hospital in compliance with those guidelines furnished free care worth $132,290 in its fiscal year ending September 30, 1977, and $151,653 in fiscal year 1978. The Hospital claimed a portion of these costs in its Medicare

---

[3] 42 CFR § 53.111 (1981).

reports and, if the claims were honored, would have been reimbursed $55,591 for 1977 and $64,710 for 1978.

Under the Medicare Act, providers of medical services to persons eligible for Medicare services are to be reimbursed for "the lesser of (A) the reasonable cost of such services, as determined under Section 1395x(v) of this title, . . . or (B) the customary charges with respect to such services . . ." 42 U.S.C. § 1395f(b)(1). The Hospital in this case sought reimbursement for "the reasonable cost of its services."

Ascertainment of the reasonable cost of services is controlled by 42 U.S.C. § 1395x(v)(1)(A), which provides in relevant part that:

> The reasonable cost of any services shall be the cost actually incurred, . . . and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be

> included, in determining such costs for various types or classes of institutions, agencies, and services; . . . . Such regulations shall (i) take into account both direct and indirect costs of providers of services . . . [so that the costs] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs . . . .

The Hospital claims that the Hill-Burton services are an indirect cost of providing care to Medicare eligible persons. Because the improved facility benefits all patients, including Medicare patients, the Hospital argues that it should be reimbursed for the percentage of the Hill-Burton services corresponding to the Hospital's percentage of Medicare patients.

The Intermediary, however, disallowed the Hospital's claim for reimbursement for Hill-Burton care on the ground that this care was "charity."

The PRRB and the Secretary affirmed this position. The disallowance was based primarily on the Secretary's regulation, which expressly excludes "charity" as a reimbursable item, 42 C.F.R. 405.420(a). The Secretary defines "charity" as "reductions in charges made by the provider because of the indigence or medical indigence of the patient." 42 C.F.R. § 405.420(b)(2). The district court, reversing the Secretary, concluded that the cost of providing Hill-Burton care was not charity because the care was not provided voluntarily, but rather was required as a condition for receiving the Hill-Burton grant.

Although the genesis of this litigation was in the Hospital's claim for reimbursement under the Medicare statute, the requirements for the service generating the claims originated in the Hill-Burton Act; therefore both Acts must be

construed. Since the answer is not clear from either Act, it is not surprising that this question has been the source of considerable litigation. Two cases have reached the circuit courts and have resulted in conflicting opinions. The Fifth Circuit has held that these costs were properly reimbursable under the Medicare program,[4] but the Eighth Circuit reached the opposite conclusion, holding that the cost of Hill-Burton required care to indigents was not reimbursable.[5]

There is much to be said for the analysis contained in each opinion, but we agree with the reasoning of Judge Heaney in the Eighth Circuit opinion, that

---

[4] Presbyterian Hospital of Dallas v. Harris, 638 F.2d 1381, rehearing en banc denied, 647 F.2d 1121 (5th Cir.), cert. denied, 102 S.Ct. 476 (1981).

[5] Metropolitan Medical Center v. Harris, 693 F.2d 775 (8th Cir. 1982).

the Secretary's regulations and construction of both statutes require the conclusion that the costs are not reimburseable.

While the provision of free services mandated by the Hill-Burton Act may not strictly conform to the dictionary definition of, nor even to the general concept of, "charity," the care to indigents required by the Hill-Burton Act is clearly encompassed by the definition given in the Secretary's regulation. We cannot say that this definition is at fatal variance with the reimbursement scheme of the Medicare Act; rather, this definition and its application to exclude Hill-Burton care from reimbursement are consistent with the limitations on Medicare reimbursement set forth in the Medicare Act itself.[6]

---

[6] 42 U.S.C. § 1395x(v)(1)(A), supra, prohibits medicare reimbursement for services to a nonmedicare patient; 42 U.S.C. § 1395y(a)(2) prohibits medicare

Moreover, providing medical care to indigents was an obligation imposed as a condition for obtaining the Hill-Burton grant. To permit the Hospital to be paid by the federal government for the "cost" of this care, under the provisions of another Act (Medicare), would defeat the intent of Congress as expressed in both of the Acts. Metropolitan Medical Center v. Harris, 693 F.2d 775 (8th Cir. 1982).[7]

For the foregoing reasons, the judgment of the district court is reversed.

REVERSED.

(footnote continued)
reimbursement for care for which an individual "has no legal obligation to pay"; 42 U.S.C. § 1395y(a)(3) prohibits medicare reimbursement where the care has been "paid for directly or indirectly by a governmental entity."

[7] See also Note, The Propriety of Reimbursement by Medicare for Hill-Burton Free Care, 130 U. Pa. L. Rev. 892 (1982).

IN THE DISTRICT COURT OF THE
UNITED STATES FOR THE WESTERN
DISTRICT OF NORTH CAROLINA
STATESVILLE DIVISION

ST-C-81-52

IREDELL MEMORIAL HOSPITAL, INC. Plaintiff, vs. RICHARD SCWEIKER, Secretary of the U.S. Department of Health and Human Services, Defendant.	MEMORANDUM AND ORDER

THIS MATTER coming on to be heard and being heard before the undersigned United States District Court Judge for the Western District of North Carolina on the 21st day of December, 1981, at the United States Courthouse in Statesville, North Carolina, on the motions of the Plaintiff and Defendant for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure; and,

Mr. Anthony H. Brett, Attorney at

Law, having appeared for the Plaintiff, and Mr. Stephen Weiss, Attorney at Law, having appeared for the Defendant; and,

The Court having heard the oral arguments of the parties and having read the pleadings, the briefs, and the other documents filed in this matter, and being of the opinion that there is no genuine issue as to any material fact and that judgment as a matter of law is proper, enters the following Memorandum and Order:

Plaintiff, Iredell Memorial Hospital, seeks judgment and an order declaring that the actual cost of providing uncompensated indigent care pursuant to its obligation under Section 291c(e)(2) of the Hill-Burton Act, 42 U.S.C. § 291 (1974) is an allowable indirect cost, reimbursable under Section 1395x(v) of the Medicare Act, 42 U.S.C. § 1395 (West. Supp. 1981).

Procedural History.

Blue Cross/Blue Shield of North

Carolina, the Defendant's fiscal Intermediary, disallowed reimbursement; the Provider Reimbursement Review Board [PRRB] upheld the disallowance by a 3-2 vote. The Defendant, Secretary of Health and Human Services, declined to review the PRRB decision, which then became a final administrative agency determination pursuant to 42 U.S.C. § 1395oo(f)(1) (West Supp. 1981), reviewable under the Administrative Procedure Act, 5 U.S.C. § 701 (1977). The PRRB decision may be overturned if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A) (1977).

Factual Background.

Plaintiff is a 182-bed general short-term care hospital located in Statesville, North Carolina. It is a qualified provider of services under the Medicare program.

Plaintiff received $1,286,568 between 1969 and 1970 as a grant under the Hill-Burton Act. As a condition of receiving the grant, Plaintiff was required to render uncompensated care to persons unable to pay. 42 U.S.C. § 291c(e)(2) (1974). Plaintiff furnished such uncompensated care during its fiscal year ending September 30, 1977 in the amount of $132,290 and during its fiscal year ending September 30, 1978 in the amount of $151,653. The amount of reimbursement in dispute is $55,591 for 1977 and $64,710 for 1978, a total of $120,301.

DISCUSSION

The Defendant bases his position of disallowance upon two arguments:

1. The Secretary's interpretation of its own regulations is entitled to a high degree of deference:

(a) Hill-Burton care constitutes "charity" under the regulations;

(b) regulations prohibit reimbursement of services to non-Medicare beneficiaries; and,

(c) regulations prohibit reimbursement of expenses where

(i) the individual to whom the services are furnished has no legal obligation to pay, and

(ii) no other person has a legal obligation to pay.

(2) Congress intended Hill-Burton "free care" to be at the expense of the hospital, not the government.

If these arguments are found not to be in accordance with the law, this Court must overturn the decision of the PRRB and order reimbursement to the hospital of the sum in dispute.

1. Deference to the Secretary.

Defendant contends that this Court must defer to the Secretary's interpretation of its own regulations, citing Batterton v. Francis, 432 U.S. 416 (1977). However, in that case the regulation at

issue was explicit in what was to be excluded from coverage under the governing Act. The Court's primary consideration in Batterton was whether the explicit exclusion was reasonably within the purpose of the Act. Id. at 429-432.

The function of this Court in this case must be distinguished, since neither the Medicare Act nor the regulations promulgated thereunder specifically address the issue of reimbursing Hill-Burton health care to those unable to pay. The function of this Court is to analyze the Medicare Act and its regulations to determine whether reimbursement of Hill-Burton expenses is consistent with the general purpose of Medicare and the intent of Congress under the Hill-Burton Act.

A provider of services under Medicare is entitled to reimbursement for the reasonable cost of services provided to

Medicare patients calculated in part as follows: "the lesser of (A) the reasonable cost of such services, as determined under Section 1395x(v) of this Title [42]. . ., or (B) the customary charges with respect to such services . . ." 42 U.S.C. § 1395f(b)(1) (West Supp. 1981).

> Section 1395x(v)(1)(A) states, "[t]he reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary . . . and shall be determined in accordance with regulations . . . . Such regulations shall (i) take into account both direct and indirect costs of providers of services . . . in order that . . . the necessary costs of efficiently delivering covered services to individuals covered by [Medicare] will not be borne by individuals not so covered, and that costs with respect to individuals not so covered will not be borne by [Medicare]."

42 U.S.C. § 1395x(v)(1)(A) (West Supp. 1981).

"Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities.

They are usually costs which are common and accepted occurrences in the field of provider's activity." 42 C.F.R. § 405. 451(b)(2) (1980).

The above provisions of the Medicare Act and its regulations reflect a general intent to reimburse the provider for reasonable direct and indirect costs of services rendered. Indirect costs which are allowed include costs related to construction: interest and depreciation. [42 C.F.R. § 419 (a) (1980) (interest); 42 C.F.R. § 405.418(a) (1980) (depreciation)].

The provision of a certain level of uncompensated care mandated by 42 C.F.R. § 53.111(h) (1980) qualifies the hospital for interest subsidies on construction and modernization projects under the Hill-Burton Act. In lieu of the payment of interest, the provision of uncompensated care is a cost of construction, which would be a reasonable cost reimbursable

under the general scheme and purposes of the Medicare Act, in the absence of language in either regulation or statute to the contrary.

1.A. Charity.

Defendant contends that the uncompensated care required by Hill-Burton constitutes "charity" as it is defined in 42 C.F.R. § 405.420(b)(2) (1980): "reductions in charges made by the provider of services because of the indigence or medical indigence of the patient", and thus it is not an allowable cost. [42 C.F.R. § 405.420 (g) (1980)].

However, the hospital would not provide this uncompensated care in the absence of a legally enforceable obligation under 42 U.S.C. § 291c. Cook v. Ochsner Foundation Hospital, 559 F.2d 968 (5th Circuit 1977). The "voluntary" nature of the application by the hospital for Hill-Burton aid may not be carried over to

characterize the nature of the provision of uncompensated care as "charity"; the concepts are distinct. A hospital applies for Hill-Burton aid for many reasons; the "voluntary" nature of economic necessity is debatable. However, the motivation behind applying for such aid would in no case be "charitable", since it is based upon self-interest and financial expansion. The word "charity" has been explored in great detail in St. James Hospital v. Harris, ___F.Supp.___(No. 80-C-735, N.D.Ill. December 4, 1981). The court in that case concluded that the characterization of uncompensated care under Hill-Burton as "charity" was "arbitrary, erroneous, and irrational." [slip opinion at 21].

1.B. Reimbursement to Non-Medicare Beneficiaries.

Defendant raises 42 U.S.C. § 1395x(v)(1)(A), quoted in part on Page 3 of this

opinion, to bar reimbursement of expenses incurred in treating non-Medicare beneficiaries, i.e. the indigents treated under Hill-Burton. Defendant contends that this cost, though mandatory for the receipt of funds to build a structure which will benefit Medicare patients, is not a cost "properly associated with the care of Medicare beneficiaries." [Defendant's brief, Page 11] Defendant quotes Harper-Grace Hospital v. Schweiker, No. 80-72082 (E.D. Mich., April 1, 1981)(slip opinion at page 7):

> although the hospital built or modernized with Hill-Burton funds benefits all patients of that facility, both Medicare and non-Medicare alike, the provision of indigent health care does not benefit Medicare recipients except for the attenuated reason that their provision is required by a grant that benefits all.

[emphasis added.]

The "attentuation" referred to by the court in Harper-Grace is obscure.

Interest payments are forwarded to a bank, not to Medicare recipients, yet interest payments are allowable costs, "required by a grant that benefits all." The recipient of the expenditure, be it banker or poor person, should not be determinative of the issue in this case. Rather, the cause of the expenditure, the reasonableness of the cost of operation, should be the focus of this case. The courts in Presbyterian Hospital of Dallas v. Harris, 638 F.2d 1381 (5th Cir. 1981), cert. denied on other gounds, 50 U.S.L.W. 3295 (October 20, 1981), and Rapides General Hospital v. Matthews, 435 F. Supp. 384 (W.D. La. 1977), vacated and remanded on other grounds, No. 77-3125 (5th Cir. October 23, 1978), held that Hill-Burton care costs were indistinguishable from other indirect costs, which are reimbursed by Medicare.

1.C. Reimbursement Where No Individual Has Legal Obligation to Pay.

Additionally, Defendant contends that 42 U.S.C. § 1395y(a)(1974) bars reimbursement:

> Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services--
>
> * * *
>
> (2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for.

A careful reading of this statutory provision discloses that the indigence of the patients treated is only one-half of the inquiry; there must also be "no other person [with] a legal obligation to provide or pay for" the health care services provided. The Hill-Burton Act is the "legal obligation" under which the hospital is mandated to provide services to those unable to pay. Cook v. Ochsner Foundation Hospital, supra. Therefore, 42 U.S.C.

§ 1395y (a) has no application to the case at bar.

This Court must conclude from the foregoing analysis, that there are no regulations promulgated by the Defendant which control this case. The only remaining source of guidance is Congressional intent.

2. Congressional Intent.

Finally, Defendant contends that "[i]n enacting the Medicare legislation, Congress nowhere evidenced the slightest intent to eliminate or to reduce hospitals' Hill-Burton free care obligations." [Defendant's brief, Page 9.] Defendant cites Harper-Grace, supra. as correctly noting that a double benefit inures to the hospital through Medicare reimbursement of Hill-Burton expenses. The first benefit is reduced construction costs; the second is government-financed indigent care, instead of the "free care" which Congress sought

to require hospitals to provide.

This issue has been most thoroughly addressed in Metropolitan Medical Center and Extended Care Facility v. Harris, 524 F. Supp. 630, 633 (D. Minn. 1981):

> Defendant's argument is premised on the assumption that Congress intended for the health care provider receiving Hill-Burton benefits to undertake the financial burden of this obligation. The legislative history of the Hill-Burton Act, however, does not provide support for defendants' argument. The general tenor of the Senate hearings on the Hill-Burton Act reflects a desire to assure availability of the facility for all people, regardless of their financial position. Hospital Construction Act: Hearings on S. 191, Before the Senate Comm. on Education and Labor, 79th Cong., 1st Sess., 189 (1945). There is no evidence of any intent to require a hospital to pay for rendering the free care, only that the facilities be made available to all people. See Debates on Senate Bill 191, Cong. Rec., Dec. 11, 1945, 79th Congress 11723, 11795-96.
>
> Initial regulations issued under the Hill-Burton Act clearly show that it was never contemplated that Hill-Burton assistance was intended to require a hospital to pay for rendering the free or below cost

> care required by the statute. As originally adopted, section 53.63 of the Hill-Burton regulations stated, in part, that "[s]uch care may be paid for wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as Community Chest or may be contributed at the expense of the hospital itself." Fed. Reg. 6179 (Sept. 16, 1947).
>
> The statute, its legislative history, and the regulations promulgated under it, all support the view that a Hill-Burton free care provider need not assume the entire financial burden of its free care obligation. The purpose of the Act is served by the facility being made available to all people, regardless of ability to pay.

After reviewing the statutes, regulations and the legislative history of both Medicare and Hill-Burton Acts, the Court is convinced that the Hill-Burton obligation to provide uncompensated care is reimbursable as an indirect cost under 42 U.S.C. § 1395x(v)(1)(A) of the Medicare Act. The Secretary's determination that the indirect costs of providing uncompensated care under Hill-Burton are not

reimbursable is erroneous and contrary to the statute and must be overturned. This opinion is further supported by the recent decisions of the PRRB in John Muir Memorial Hospital v. Blue Cross Assn., [1981] 4 Medicare and Medicaid Guide (CCH) ¶31,492 and Gaston Memorial Hospital, Inc., v. Blue Cross Assn., [1981] 4 Medicare and Medicaid Guide (CCH) ¶31,545. In both cases, the PRRB ruled that Hill-Burton uncompensated care is reimbursable, reversing its prior position, which it took in the case at bar.

IT IS THEREFORE ORDERED that:

1. The plaintiff's motion for Summary Judgment should be and is hereby allowed.

2. Defendant's motion for Summary Judgment is denied.

3. Plaintiff's actual expenses incurred in providing uncompensated care mandated by the Hill-Burton Act is reimbursable under the Medicare Program.

4. Defendant take all necessary steps to readjust Plaintiff's

Cost Reports and Reimbursements from the Medicare Program for its costs in complying with its Hill-Burton uncompensated care obligations for the Plaintiff's fiscal years ending September 30, 1977 and September 30, 1978.

5. The Defendant shall additionally reimburse Plaintiff for annual interest on the amount of reimbursement [$120,301.] to be computed in accordance with 42 U.S.C. § 1395oo(f)(2) (West. Supp. 1981).

6. Each party shall pay its own costs, including attorney fees.

This the 5th day of January, 1982.

/s/
ROBERT D. POTTER
UNITED STATES DISTRICT
COURT JUDGE

PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION
ON THE RECORD
81-D26

PROVIDER - Iredell Memorial Hospital
Statesville,
North Carolina

PROVIDER NO. 34-0039

VS

INTERMEDIARY - Blue Cross
Association/Blue
Cross & Blue Shield
of North Carolina

DATE OF HEARING - January 9, 1981

COST REPORTING PERIOD ENDING - September 30, 1977 and 1978

CASE NO. - 80-127

INDEX

	Page No.
Issue	2
Summary of Facts	2
Citation of Applicable Law, Regulations, and Program Instructions	3
Conclusions and Findings	3
Decision	5

Exhibit A

ISSUE:

Whether the Intermediary's adjustments pertaining to the disallowance of costs relating to Hill-Burton free care are correct?

SUMMARY OF FACTS

The Provider is a 182-bed, voluntary, nonprofit corporate, general, short-term hospital owned by the municipality, but operated by a nonprofit organization.

In the late 1960's plans were made to construct a new wing to the hospital, increasing the number of beds from 100 to the present level of 182. To facilitate this expansion, the Provider received $1,286,568 as a grant under the Hill-Burton Act (42 USC 291 et seq.). As a condition thereof, the Provider was legally required to furnish a reasonable amount of uncompensated care, for a period of 20 years, to those persons unable to pay.

The Provider furnished $132,290 in uncompensated Hill-Burton care during the fiscal year ending September 30, 1977 and $151,653 in uncompensated care during the fiscal year ending September 30, 1978. The concomitant effect of adding these amounts to allowable costs for Medicare reimbursement for those periods is $55,591 and $64,710, respectively.

The Intermediary disallowed the Provider's claim that the charges for uncompensated services assigned to the Hill-Burton obligation should be added to reimbursable costs. The Intermediary concluded that the disallowance is a direct and proper

application of Medicare regulations and policy. Specifically, the Intermediary treated the amounts of uncompensated care as charity or bad debt allowances, pursuant to Section 405.420 of the Regulations. It treated the amounts as allowances and not costs. Further, the Intermediary argued that the inclusion of the allowance amounts in the Provider's cost reports would mean that the Medicare program is reimbursing the Provider three times in each cost report:

1. Once for the total cost incurred, during that fiscal year end, to generate the charges incurred during that year;

2. Once for the loss of revenue related to the uncollectible amounts;

3. One for the depreciation expense on the building addition, which was constructed with the aid of the original $1,286,568 in the Hill-Burton funds.

On the other hand, the Provider argued that since the "free care" is mandated by the Hill-Burton Act -- and the benefits of Hill-Burton funds are derived by all patients, Medicare and otherwise, the program should bear its proportionate share of the unrealized revenues. Since expansion, an increase in type and amount of services, would not have been feasible without the commitment, the obligations -- not just the benefits -- should be assumed by the Medicare program.

The Provider cited the decision in Rapides General Hospital v. Mathews, 435 F Supp 384 (W. D. La. 1977(, (vacated and remanded

to the District Court by the Court of Appeals for the Fifth Circuit in October 1978) where the Chief Judge disagreed with the Intermediary for disallowing free care costs. Although the Decision was vacated, the Order reversing the Decision did not turn on this point.

CITATION OF APPLICABLE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

I. Law, Title XVIII of the Social Security Act

Section 1861 (v)(1)(A) - Reasonable Cost

II. Regulations - 42 CFR 405, Regulation No. 5, Subpart D

1. 42 CFR 405.420 - Bad debts, Charity and Courtesy Allowances

2. 42 CFR 405.451 - Cost Related to Patient Care

III. Program Instructions

Section 328, PRM (HIM-5) - Charity, Courtesy & Third-Party Payer Allowances-Cost Treatment

CONCLUSIONS AND FINDINGS

The Provider Reimbursement Review Board, after consideration of the facts, parties' contentions, and evidence presented concludes and finds that the Intermediary's adjustments are affirmed.

Over the years, this issue has been clouded by debate as to whether care rendered by a

provider without receiving payment constitutes "charity"--particularly if the provider is required to render "uncompensated services" as a condition of a government loan or grant. This is not the real issue. Clearly, the issue is whether any element of "uncollected revenue" (or to employ the providers' characterization, the "unrecovered cost") attributable to delivering care under Hill-Burton should be recognized as a reimbursable cost under the Medicare Program.

Years before the advent of the Medicare Program, the American Hospital Association's Principles of Reimbursement stated that charity, bad debts and courtesy allowances are not costs, but reductions from revenue. That oft-repeated definition is basic to the issue in this case since Medicare reimbursement is based on costs--not on a provider's financial requirements.

The Provider in the instant case is now asking that total costs be increased by the amount of uncollected revenue (or in its terms, unrecovered cost) which fulfills its Hill-Burton obligation. The following hypothetical figures illustrate the reimbursement effect of the parties' contentions.

1.	Cost of providing care to all patients	$1,000,000
2.	Amount of uncollected revenue attributable to Hill-Burton patients	30,000
3.	Cost of providing care to all patients based on the Provider's contentions	

	(lines 1 & 2)	1,030,000
4.	Medicare patient utilization	50%
5.	Payment under Medicare principles of reimbursement (line 1 & 4)	500,000
6.	Payment sought by the Provider (line 3 & 4)	515,000

The Board majority does not agree with the Provider's method of computing Medicare payments. The assumption of a Hill-Burton obligation by the Provider does not convert the uncollected revenues into additional reimbursable costs under the Medicare principles of reimbursement. In the cost finding process, costs incurred by the Provider in rendering care to all patients--Medicare, Medicaid, private insurors, self-pay and non-pay are first determined. These total costs (line 1 in the above example) are then apportioned to various classes of patients and Medicare pays its share of these costs. This is not to say the Provider does not experience a financial problem as a result of not recovering the revenue related to its Hill-Burton obligation.

The basic root of the issue is that the basis of Medicare payments is actual operating costs as defined by Medicare principles of reimbursement--not the Provider's financial requirements.

DECISION

The Intermediary's adjustments are affirmed. The Provider may not be reimbursed for the costs of the Hill-Burton

uncompensated services (free care).

Board Members Participating

Thomas M. Tierney
Carolyn B. Lewis
H. Joseph Curl (Dissent)
James Houdek, Jr., CPA (Dissent)
Bette A. Kraus

FOR THE BOARD /s/
Thomas M. Tierney
March 6, 1981 Chairman

Dissenting Opinion of H. Joseph Curl and James Houdek

42 CFR 405.420(a) states simply, categorically, and unequivocally that "bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost." There are many compelling reasons for this Regulation and the writers of this dissenting opinion are in complete agreement with the meaning of what is intended. It would be inappropriate and irresponsible for the Medicare program to reimburse hospitals for charity care since this would in effect offer a blank check to providers to pay for the delivery of health services.

The problem at hand is the collision of conflicting interpretations of regulations emanating from two separate statutes that are implemented by the (now) Secretary of Health and Human Services. The first Regulation at 42 CFR 53.111 is related to the Hill-Burton Act. This Regulation deals with the level of "uncompensated services" that must be made available to "persons unable to pay." In no place does this Regulation use the term "charity." In the simplest sense, "charity" means a voluntary act and in no sense is charity involved in this Regulation. Section 42 CFR 53.111 specifies in great detail that a provider must make "assurances" that services will be made available at (c)(1), and that "compliance reports" will be filed within 120 days of the end of the fiscal year at (e)(1). In fact, this legal requirement has been recognized by the courts in Cook v. Ochsner Foundation Hospital 319 F. Supp 603 (E.D. La 1970), Euresti v. Stenner 458 F. 2d.1115 (CAIO, 1972), and Corum v. Beth Israel Medical

Center 359 F. Supp 909 (S.D. N.Y. 1973) among others. It is clear that by accepting financial assistance from the Federal Government through the Hill-Burton program, medical institutions have incurred a legal obligation to provide "uncompensated services" enforceable through the courts.

The second part of this regulatory collision is in the aforementioned 42 CFR 405.420. Paragraphs (1)(a) and (2) clearly state that charity allowances are not to be included in allowable costs. The meaning is clear, and the Provider makes no claim for the charity care it rendered as a chartered charitable institution. It simply makes claim for the appropriate amount of "uncompensated services" rendered to "persons unable to pay" which were required by law, and by contract, and by assurance before the Hospital could receive either the grant or the loan guarantee.

The resultant benefits of an increased patient care capacity, a modernized plant, additional services -- all achieved as a result of this federal funding -- accrues to the benefit of the entire health care community, including Medicare beneficiaries. Without the additional funding made possible by the Hill-Burton agreement, the Medicare patient, as well as all other patients, would not receive the maximum care available. Since the benefits inure to all patients, the costs are related to patient care, and cannot be exempt itself from sharing in those patient-related costs.

This is the precise point at which there is a confusion and differing opinions. Because the purpose of the funds in the first place is to make services available to all classes of patients, the free care

obligation becomes a financial responsibility of all payors. In short, the Hill-Burton obligation is in fact an overhead, or indirect cost of delivering health services not unlike medical services provided to employees as a fringe benefit which become a labor cost. The problem is not one of cost finding, but of cost apportionment. The cost of the Hill-Burton obligation should be apportioned to all payors in the same manner that other indirect costs are apportioned. To do less is to subvert the fundamental premise of the Medicare Act which states that the program will pay for all reasonable direct and indirect costs.

The bedrock of the Intermediary's position is that the Medicare program will pay only for care received by program beneficiaries and since the recipients of the free care are persons other than those covered by Medicare, the program is precluded from paying for such free care. The decision in Rapides General Hospital v. Mathews, 435 F. Supp 384 (W.D. LA 1977), (vacated and remanded back to the District Court by the United States Court of Appeals for the Fifth Circuit in October 1978), speaks eloquently to this point:

> "Plaintiff does not assert that the free care beneficiaries are Medicare recipients and that their costs are reimbursable as such. Rather, Plaintiff argues that the costs of free care are incidental allowable costs, similar in nature to interest or depreciation, neither of which go directly to benefit Medicare patients, but which nonetheless inure as a residual benefit to them and are

thus compensable on that basis. Consequently, defendant's response functions in a misplaced context."

This issue then turns on the fundamental principle of the Medicare program that costs with respect to individuals covered by the program will not be borne by individuals not so covered and, conversely that costs with respect to individuals who are not under the program will not be borne by the program -- 42 USC Section 1395(v)(1)(A) and 42 CFR 405.452(e)(1). The Intermediary's adjustment, therefore, runs counter to both the Regulations and the Statute.

That a single department of the government would continue to administer the regulation of two of the most successful statutes of health legislation in such a contradictory fashion defies logic. A disservice is being done to Medicare beneficiaries, recipients of health care services, and to the providers of health service alike.

We make the plea that careful consideration be given to the solution of this dilemma and regulations be properly interpreted in such a manner as to reduce the unnecessary tension and public expense being caused in the delivery of needed health services.

/s/
H. Joseph Curl

/s/
James Houdek

SUPREME COURT OF THE UNITED STATES

No. A-874

IREDELL MEMORIAL HOSPITAL, INC.,

Petitioner,

v.

SECRETARY OF HEALTH AND HUMAN SERVICES

ORDER EXTENDING TIME TO FILE PETITION FOR WRIT OF CERTIORARI

Upon Consideration of the application of counsel for petitioner~~s~~,

It Is Ordered that the time for filing a petition for writ of certiorari in the above-entitled cause be, and the same is hereby, extended to and including July 10, 1983.

/s/ Warren E. Burger
Chief Justice of the
United States.

Dated this 27th
day of April, 1983

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Washington, D.C. 20201

Re: Iredell Memorial Hospital v. BCA/BC and Blue Shield of North Carolina, Determination of Reasonable Costs for Cost Reporting Period Ending 9/30/77, and 9/30/78, PRRB Decision No. 81-D26

I recommend that the Deputy Administrator, Health Care Financing Administration, decline to review, on own motion, the decision entered by the Provider Reimbursement Review Board in this case.

/s/ Erica L. Gosnell
Erica L. Gosnell
Attorney-Advisor

APPROVED:

Date: 4/17/81 /s/Paul Willging
Paul R. Willging, Ph.D.
Deputy Administrator
Health Care Financing
Administration

U.S. Const. Art. III, § 1

The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

U.S. Const. Amend. V

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

5 U.S.C. § 706(2)(A)

Scope of review

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall--

* * *

(2) hold unlawful and set aside agency action, findings, and conclusions found to be--

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

42 U.S.C. § 291c(e)

General regulations

The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health and Human Services, shall by general regulations prescribe--

* * *

State plan requirements; assurances necessary for approval of application

(e) that the state plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that (1) facility

or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

42 U.S.C. § 1395f(b)(1)

Amount paid to provider of services

The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1395e of this title, be--

(1) the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title, or (B) the customary charges with respect to such services;

42 U.S.C. § 1395x(v)(1)(A)

Reasonable cost; semi-private accommodations

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types of classes of institutions, agencies, and services; except that in any case to which paragraph (2) and (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations

or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs

established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs or providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments

where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

42 U.S.C. § 1395oo(f)

Finality of decision; judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters

in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final

decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, nothwithstanding any other provisions in section 405 of this title.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal

to the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

Tax Equity and Fiscal Responsibility Act of 1982, section 106 (96 Stat. 337)

Prohibiting Payment for Hill-Burton Free Care

Sec. 106. (a) Section 1861(v)(1) of the Social Security Act is amended by adding at the end the following new subparagraph:

"(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs."

(b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed

prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals.

42 C.F.R. § 405.311

Nonreimbursable expenses; individual has no legal obligation to pay for items or services.--Payment may not be made under title XVIII of the Act for expenses incurred for items or services for which the individual who is furnished such items or services has no legal obligation to pay, and which no other person (by reason of the individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for. For example, no payment may be made for items or services, such as a chest X-ray, that are rendered free of charge by health organizations without regard for the individual's ability to pay. This exclusion does not prevent payment for items or services furnished by a group health prepayment plan to a member of the plan. Neither does it apply to items or services paid for by a

governmental entity (with respect to such items or services, see § 405.312).

42 C.F.R. § 405.312

Nonreimbursable expenses; items or services paid for by governmental entity.--Payment may not be made under title XVIII of the Act for expenses incurred for items or services that are paid for directly or indirectly by a governmental entity, except:

(a) Payment may be made for items or services furnished under a health insurance plan established for employees of the governmental entity.

(b) Payment may be made for items or services furnished an individual under a program based on one of the titles of the Social Security Act.

(c) Payment may be made for items and services furnished an individual in or by a participating hospital operated by a State or local governmental entity, where such hospital is a general or special hospital serving the general community

community, including a mental or tuberculosis hospital or a hospital for treatment of infectious disease.

(d) Payment may be made for items and services paid for by a State or local governmental entity and furnished an individual as a means of controlling infectious diseases or because of the individual's medical indigency, whether or not such services are furnished in a hospital.

(e) Payment may be made for items and services furnished by participating hospitals and skilled nursing facilities of the Indian Health Service.

(f) Payment may be made for items and services furnished by a public or private health facility which receives United States Government funds under a Federal program which provides support to facilities which furnish health care services (other than a Federal provider

of services) provided the facility receiving such Federal support customarily seeks reimbursement for items and services not covered under title XVIII of the Social Security Act, from all resources available for the health care of its patients, e.g., private insurance, patients' cash resources, etc. Payments that are made for such items and services covered under supplementary medical insurance shall be subject to the individual's deductible and shall not exceed 80 percent of charges related to reasonable costs that the facility incurs in providing the items and services. The facility's charges to the individual must not exceed 20 percent of such charges plus any unsatisfied deductible amounts and charges for noncovered services.

(g) Payment may be made in other cases as specified by the Secretary under authority of section 1862(a)(3) of the Act.

42 C.F.R. § 405.402

Cost reimbursement; general--(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual

costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services for services rendered health insurance program beneficiaries are subject to the provisions of §§ 405.455 and 405.460.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current

payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both nonprofit organizations and profitmaking organizations.

(6) That there should be a recognition

of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of §405.435, "Nonallowable costs related to certain capital expenditures." With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research

purposes, over and above usual patient care, will not be included.

(3) Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs.

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includible in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be

reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) rendered in a teaching hospital may be reimbursed as a provider cost (see § 405.465) where elected as provided for in § 405.521 of this Part.

(d) In developing these principles of reimbursement for the health insurance

program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be on an historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical cost basis must be used. All assets actually in use for production of services for title XVIII beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce

the interest expense that is allowable as a program cost.

(e) [Revoked.]

(f) A return on the equity capital of proprietary facilities is an allowable cost in profitmaking organizations. The rate of return may not exceed one and one-half times the average long-term rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(g) The Health Care Financing Administration is authorized to issue temporary instructions modifying the provisions of this subpart to the extent it finds appropriate for cost reporting periods ending after June 30, 1973, in order to implement sections 201 (Coverage for Disability Beneficiaries Under Medicare) and 299I (Chronic Renal Disease Considered to Constitute Disability) of Pub. L. 92-603. In so doing, rules may be developed for

establishing limits on costs and services above which reimbursement shall be made only upon appropriate justification. For special rules concerning health maintenance organizations (HMO's) and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§ 405.2042(b)(14) and 405.2050(c).

42 C.F.R. § 405.403(b)

In the study and consideration devoted to the method of apportioning costs, the objective has been to adopt methods for use under title XVIII of the Act that would, to the extent reasonably possible, result in the program's share of a provider's total allowable costs being the same as the program's share of the provider's total services. This result is essential for carrying out the statutory directive that the program's payments to providers should be such that the costs of covered services for beneficiaries would not be passed on to nonbeneficiaries, nor would the cost of services for nonbeneficiaries be borne by the program.

42 C.F.R. § 405.420

Bad debts, charity, and courtesy allowances.--(a) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

(b) Definitions--(1) Bad debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

(2) Charity allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the

patient.

(3) Courtesy allowances. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) Normal accounting treatment: reduction in revenue. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(d) Requirements for title XVIII. Under title XVIII of the Act, costs of covered services furnished beneficiaries

are not to be borne by individuals not covered by the health insurance program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than beneficiaries of title XVIII. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts which remain unpaid are added to the title XVIII share of allowable costs. Bad debts arising from other sources are not allowable costs.

(e) Criteria for allowable bad debt.

A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

(2) The provider must be able to establish that reasonable collection efforts were made.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) Charging of bad debts and bad debt recoveries. The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such

cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

(g) Charity allowances. Charity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs. The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.

42 C.F.R. § 405.451

Cost related to patient care.--(a) Principle. All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under title XVIII of the Act and furnished to program beneficiaries or the customary charges to the general public for such services as provided for in § 405.455.

(b) Definitions. (1) Reasonable cost. Reasonable cost of any services must be determined in accordance with

regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both title XVIII and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the

actual cost of services rendered to beneficiaries during the year.

(2) Necessary and proper costs. Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity.

(c) Application. (1) It is the intent of title XVIII of the Act that payments to providers of services should be fair to the providers, to the contributors to the health-insurance trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in title XVIII of the Act for payment of

reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of beneficiaries of title XVIII of the Act. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal stand-by costs. However, where the provider's operating costs include amounts not

related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

47 Fed. Reg. 43654, 43658
(October 1, 1982)

42 CFR 405.420 is amended by revising paragraphs (b)(2) and (g) as set forth below:

§ 405.420 Bad debts, charity, and courtesy allowances.

* * * * *

(b) definitions.--

* * * * *

(2) Charity allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.

* * * * *

(g) Charity allowances. Charity allowances have no relationship to

beneficiaries of the health insurance program and are not allowable costs. These charity allowances include the costs of uncompensated services furnished under a Hill-Burton obligation. (Note: In accordance with Sec. 106(b) of Pub. L. 97-148 (enacted September 3, 1982), this sentence is effective with respect to any costs incurred under title XVIII of the Social Security Act, except that it does not apply to costs which have been allowed prior to September 3, 1982, pursuant to a final court order affirmed by a United States Court of Appeals). The cost to the provider of employee fringe-benefit programs is an allowable element of reimbursement.